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Maternity Reports: LSA SHSCT Supervisory Roadshow 5th Nov 2014

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Maternity Reports

**LSA SHSCT Supervisory
Roadshow 5th Nov 2014**

Outline of session

By the end of the session you will be able to discuss the following reports and their relevance to midwifery practice –

- Transforming your Care (2011)
- Maternity Strategy for Northern Ireland (2012)
- The Francis Report (2012)
- Ombudsman Report (2013)

A Review of Health and Social Care in Northern Ireland (TYC)(2011) John Compton

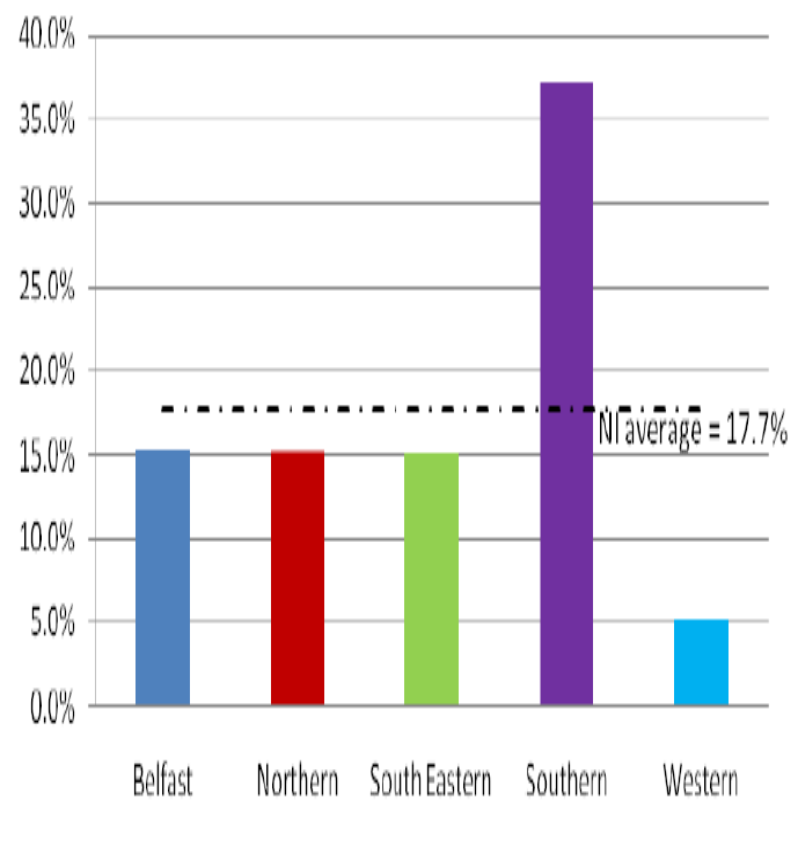
Increasing Pressure on Health and Social Care - unassailable case for change.



Transforming Your Care

A Review of Health and Social Care
in Northern Ireland

Pressures within the maternity services



- Increase in Births 2000- 2010 by 18%- 25,315 in 2010
- Sharpest increase seen here in SHSCT
- Number of births levelled in last 3-4 yrs 24,279 in 2013. 5,704 in SHSCT in 2012
- Average age of women giving birth is 30 years- higher rates of complexity
- In 2013, 10% of births were to mothers born outside the UK and Ireland – steadily increasing
- High rates of interventions -SHSCT 33.8%. Overall NI 29.8% . England 25%

Implications for delivery of maternity services

- Written and oral information for women to enable an informed choice about place of birth
- Access to Screening programmes
- Services in consultant-led obstetric and midwife-led units available dependent on need
- Promotion of normalisation of birth,
- Hospital care provided but discharging mothers into the care of local services
- Midwives leading care for normal pregnancies and labour
- Reduction over time of unnecessary interventions
- Continuity of care for women throughout the maternity pathway
- A regional plan for supporting mothers with serious psychiatric conditions.

A Maternity Strategy for Northern Ireland 2012-2018

DHSSPS carried out a review of policy on maternity service provision in Northern Ireland.

The review focused on the best available evidence for the care and treatment of mothers-to-be; quality, safety and service sustainability; wider workforce issues; and professional roles and responsibilities.

The Strategy is outcomes focused.

The six outcomes were :-

1. Give every baby and family the best start in life;
2. Effective communication and high-quality maternity care;
3. Healthier women at the start of pregnancy (preconception care);
4. Effective, locally accessible, antenatal care and a positive experience for prospective parents;
5. Safe labour and birth (intrapartum) care with improved experiences for mothers and babies; and
6. Appropriate advice, and support for parents and baby after birth

Maternity Strategy NI (2012) Recommendations – what does this mean for you ?

- Promotion of public health messages
- Promotion of normality
- Women facilitated to make informed choices
- Maternity communication protocol for sharing of information NIMATS and HHMR
- Collection of data sets that will contribute to a regional dashboard
- Pre conceptual care for women with medical conditions by GP
- Facilitation of early contact with midwife

continued

- Booking scans and NIMAT accessible in community
- Midwife as main carer for women in normal pregnancy
- Complex obstetric conditions care led by obstetrician.
- Women centred parent craft education
- HSC to maximise choice in intrapartum care

Francis report (2012)

“If there is one lesson to be learnt I suggest it is that people must always come before numbers”

*We need a **patient centred culture, no tolerance of non compliance with fundamental standards, openness and transparency, candour to patients and caring, compassionate practice ,”***

http://www.youtube.com/watch?feature=player_embedded&v=4lySJlm1EnM



Key findings

- Appalling suffering of many patients, failure of care and compassion, warning signs ignored
- Serious failure of the Trust Board, ignored patient voices, focused on targets and finances
- Systems of checks and balances failed patients
- In total 290 recommendations along 5 themes

“ I suggest that the Board of any Trust could reflect on their own work in the light of what is described in my report”

Robert Francis, QC

Recommendations

- Trusts and boards required to account for its stewardship of money
- NHS-funded student nurses to spend up to a year working on the frontline as healthcare assistants
- Nurses' skills to be revalidated, similar to that of medical revalidation , to ensure their skills remain up to date and fit for purpose
- Healthcare support workers and adult social care workers will now have a code of conduct and minimum training standards, both of which have been published
- Chief Inspectors of Hospitals and Social Care will be appointed

Continued

- A new statutory '**Duty of Candour**' requiring all NHS staff and directors to be open and honest when mistakes happen.
- More **powers to suspend or prosecute boards and individuals** should standards of care not be maintained. Breach should result in regulatory consequences, There should be criminal liability where serious harm or death has resulted to a patient
- Problems detected and dealt with quickly
- Commits to support a culture of zero harm and compassion

continued

- Only registered people should care for patients
- Requirement to comply with a prescribed code of conduct for directors.
- Complaints should be published on hospital websites
- GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services

Morcombe Bay Report

- Between January 2004 and June 2013 there were a series of deaths of mothers and newborn babies in the maternity and neonatal services unit at Furness General Hospital.
- Several reviews took place during this period. However, these reviews have not given those affected confidence that all of the facts have been heard and all of the underlying issues have been resolved.
- On 12 September 2013 the Secretary of State for Health therefore announced an independent investigation into Morecambe Bay Maternity and Neonatal Services

Ombudsman report (2013)

Background / case study –

- Investigation of how complaints (4 by the Father and 1 by the Grandfather) were handled around the unavoidable death of a baby in 2008.
- Prior to this there had been 2 external reviews, LSA Report and an inquest
- 25th Oct Mother had spontaneous rupture of membranes around term went to Furness General Hospital Maternity Unit
- Had complained to the midwife of being unwell the week before - headaches and sore throat –this discussion was not recorded
- Sent home returned asked to return next day – did return sent home again not in labour
- Returned following day 27th Oct in labour give birth to a baby boy
- Birth and A/S were described as normal in the records – baby cried immediately at birth and didn't require any intervention.

Continued

- Father account was different – baby did not cry at birth and required O2
- First 25 hours of babies life was not recorded – chart went missing including observation sheet
- 27th Oct following birth the mother became ill with pyrexia IV antibiotics were administered
- Baby was described by father as wheezy mucousy and breathing fast
- Temperature was low between 35.8 and 36.1 paed's were too busy to review baby. Transferred to heated cot twice by midwife
- 28th Oct at 10.30 mother became very concerned re babies condition asked for Paed to see.
- Condition continued to deteriorate and he was transferred to two different Trusts for intensive treatment.
- On 5 November 2008 baby sadly died from pneumococcal septicaemia

Findings of the report

- The Trust did not answer the family's questions openly and honestly and did not learn from what they found.
- A lack of openness by the Trust and the quality of their investigations of these complaints caused a loss of trust and further pain for the family.
- Early records were found to be missing
- Statements from staff had been rewritten and changed
- Evidence found of collusion amongst midwives about the fluctuation of the baby's temperature in preparation for the inquest.
- A change in culture is needed on how complaints are dealt with at both Board and Trust level

Midwifery supervision and regulation: recommendations for change. (2013)

Report following the completion of three investigations into complaints from three families

- Identified that midwifery supervision and regulatory arrangements at local level failed to identify poor midwifery practice
- Current systems do not always allow information about poor care to be escalated effectively into hospital clinical governance or the regulatory system.
- Fail to learn from mistakes
- Midwifery supervision and regulation should be separated;
- NMC should be in direct control of regulatory activity.

In conclusion – NMC

“Midwifery supervision may have real merits in the support it provides for midwives across the country on a daily basis. However, those strengths do not extend to the regulatory role of supervision.”